To ANY DOCTOR or HOSPITAL_____DATE_____

Please furnish **Workers' Compensation Program, Box 2489, Window Rock, AZ 86515** with a report and all information in your possession regarding my condition.

Signed:_____

I am willing that a photostat of this authorization be accepted with the same authority as the original.

MEDICAL REPORT

PATIENT	Name_____Age_____Address_____ Occupation_____Employed by_____
HISTORY OF CONDITION	Date of Accident_____20____History as described by patient_____
	Date of your 1st treatment_____
X-RAY	Date Taken_____20____Where Taken_____ Findings_____
DIAGNOSIS Describe and Locate Character And extent Of injury	
CONTRI-BUTING FACTORS	In your opinion, is the disability a result of above described accident solely?
PROGNOSIS	
	Any probable permanent results ☐ NO ☐ YES
Estimate Of total and Partial disability	Total disability estimate_____Weeks_____Days. Ended_____20_____ Partial disability estimate_____Weeks_____Days. Ended_____20_____

Physician's
Signature:_____ Date:_____